The Maryland
Department of Juvenile Services

Joint Chairmen's Report

Appendix

December 1, 2003

IMPLEMENTATION OF THE WRAPAROUND SERVICES DELIVERY APPROACH
TO YOUTH IN THE JUVENILE JUSTICE SYSTEM

Every child will become a self-sufficient productive adult.

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

Kenneth C. Montague, Jr.
Secretary

APPENDIX A

Members of House Bill 1386 Community Based Services Subcommittee

Name	Agency
Andrea Alexander	GOCCP
Jack Altfather	DHR
Marcia Andersen	DHMH/MHA
Jennifer Brienza	Parent
Eric Bruns	University of Maryland, Baltimore
Jenny Crawford	Collaboration Council/Community Kids
Michael Demidenko	Baltimore County DSS
Barbara DiPietro	DHMH
Scott Finkelson	OCYF
Betty Flint	DHMH
Colleen Gauruder	DHMH/DDA
Gerry Grimm*	Family League of Baltimore City
Maura Harford	MSDE
Sara Hunter	DJS
Rosemary Johnston	MSDE
Kathy Lally	Montgomery County LMB
Jim McComb	MARFY
Cristine Marchand	The Arc of Maryland
Tom Merrick	MHA/DHMH
Mark Mittelman	Baltimore County CSA
Amanda Owens	OCYF
Donna Riley	MSDE
Stephany Savar	Carroll County Schools
Judith Schagrin	Baltimore County DSS
Marian Sinclair	Mid Shore Mental Health Systems
Nesee Smith	On Our Own
Steven Sorin	MSDE
Denise Sulzbach	DJS
Cathy Surace	MDLC
Mary Beth Tierney	FIT/Parent
Jane Walker	Maryland Coalition of Families

* Mr. Grimm was the co-chair of the Financial Subcommittee for HB 1386 and contributed greatly to the budget portion of this report.

APPENDIX B

WRAPAROUND CASE EXAMPLE

The following example illustrates one application of the 10 principles of the wraparound model, and attempts to demonstrate where definable procedures may be used to achieve them.1 The following example details methods employed to achieve the 10 core principles and, where appropriate, describes where alternative processes may have been employed to do so. The names of the youth and family members and some details have been changed to protect the family's identity. This case study is drawn from those described in Kenziora, Bruns, Osher, Pacchiano, and Meija (2001).

Laura, an eight-year-old girl of Caucasian and African-American descent, was referred to an interagency project using the wraparound model after a six-month stay in a residential treatment center (RTC). Laura was originally placed in regular foster care at age five when it was determined that her biological mother was not able to provide a safe home for Laura and her sister because of involvement in drugs and street life. Laura reportedly witnessed significant abuse of her mother at the hands of her father and other men, and was herself the victim of emotional and physical abuse. Shortly after placement in foster care, Laura was sexually abused by another foster child in the home, after which she was placed in the custody of Cathy, her maternal grandmother, with services from the local mental health center.

However, Laura's behavior quickly deteriorated. She became physically aggressive, threatening others with knives and other household tools, and also became sexually aggressive toward her sister. She also would occasionally become dissociative, having a blank stare and screaming that her assailant was in the house. These behaviors led to the six-month residential placement. At the end of this stay, Cathy was adamant that Laura return to her home rather than transition to foster care, a setting in which Laura had been abused previously. However, providers at the residential treatment center staunchly advocated for therapeutic foster care, because they viewed Cathy, who herself had a history of substance abuse and incarceration, as lacking necessary skills to care for Laura. During this debate, Cathy was referred to the interagency wraparound project by a neighbor, a social worker familiar with the service delivery system.

Element 1: Community-based. In order to facilitate an alternative plan of returning Laura to her grandmother's house, Cathy was aided by the director of the local Federation of Families for Children's Mental Health (FFCMH), which collaborated with the local mental health and social services agencies in administering wraparound. After they found that there was no child protective services order for Laura, FFCMH advocates immediately began attending transition-planning meetings with Cathy and RTC staff to support a community-based placement in the home. As one advocate said to RTC staff, "If you're going to put $4,000 per month into a therapeutic foster home, why can't we spend the same money and put the ‘therapeutic’ into Cathy's home?" As described below, Cathy and her team eventually identified supports the family needed to keep Laura at home, and the project secured these supports through flexible funding mechanisms.

Element 2: Team-driven. Once the decision to transition Laura home was in place, FFCMH helped Cathy identify the persons in her life she wished to have on the child and family team. The team's first step was to convene for a three-session ‘training’ that actually functioned as initial team meetings. One of the first tasks of this training was to identify what services and supports were needed in order for Laura to remain at home with her grandmother, two sisters, and 12-year-old aunt (Cathy's daughter). These included finding a larger house to rent that was closer to providers and in which Laura could have her own room; installing alarms on Laura's bedroom door; and securing formal services such as respite, tutors, parent training and other in-home

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1 This case example and explanation was taken from: Bruns, Eric J (September 2003). *Serving Youths with Emotional and Behavioral Problems in Maryland: Opportunities for Use of the Wraparound Approach*, Attachment A.

supports to assist Cathy in providing caregiving. Flexible funds from the interagency project were used to provide all such formal and informal supports that were identified in these intensive initial planning meetings, including money for a security deposit on the new house that was rented within two weeks of intake into services.

Following these initial meetings the team convened on an 'as-needed' basis to solve problems faced by the family, to assess progress, to set new goals, or to identify "action opportunities" to meet goals. However, Cathy's methods of accessing team members to help set and accomplish her family's goals were primarily her decision. Often, she would mobilize team members -- be they formal service providers or community supports -- through informal communications such as phone calls. On other occasions, she and her supports would decide that a full team meeting was necessary. As such, 1-2 months would occasionally pass between full team meetings. An alternative practice would be a more proactive team meeting schedule in which the full team meets monthly or bi-monthly; however, in the current example, it could be argued that the principle of "family-centered" was considered more primary than that of "team-driven."

Element 3: Families are partners. For the project in the current example, the initial team "training" emphasized from the outset "The parent [or grandparent, in this case] is an integral part of the team and has ownership of the plan" and "The plan is family-centered rather than child centered." As described above, team meetings demand that the family members be the focal point in identifying goals and the requirements necessary to meet these goals. In addition, the very construction of the team was driven by Cathy and her daughters. Before the initial training, a team composition exercise was conducted with Cathy and FFCMH advocates. Laura was drawn at the center of a diagram, followed by concentric circles that included immediate family members in the next ring; friends and community supports in the second ring; and professionals and service providers in the most distal ring. Such an exercise encouraged brainstorming about inclusion of team members and also was referred to during service planning as a method of ensuring primacy among the most proximal supports to the family. For example, the initial training included very few formal providers, because primacy was granted to family members, friends, and informal support persons. As another example, the role of the family's case manager (employed by the interagency project) was not to coordinate or dictate services, but rather primarily to ensure that funds required by Cathy and her team were quickly and efficiently mobilized.

Element 4: Individualized and strengths-based. As noted above, one of the purposes of the initial team meetings was to brainstorm the specific needs of Cathy's family. This included an exercise called a "24-7 Chart," an exercise in which Laura's entire week was described, hour-by-hour, by family members as a way of ensuring that a full complement of needs was identified. During the course of wraparound, regular meetings were held to assess success toward initial goals, which were broadly defined by Cathy and her support network as (1) "To keep Laura home and provide for safety," and (2) "to move to a bigger house closer to [the center of town]." For each goal, and goals that were identified in subsequent team meetings, specific steps -- or "action opportunities" -- were delineated. Services and supports changed with each meeting, with family members always taking the lead in identifying goals. As time progressed, formal supports that were required initially, such as intensive in-home professional support to model methods of behavior management, yielded to more informal supports such as karate lessons for the three oldest children in the home.

To ensure that services were strengths-based, an intensive exercise was conducted at the initial meeting to identify the strengths of the child, family members, and all other team members. These strengths then were posted on the walls during all team meetings as a way of assisting in identification of "action opportunities" needed to meet goals. For example, Cathy's desire to "build the family and keep it together" was identified as a strength, and as such she became empowered to advocate for necessary services and supports, and was encouraged to work

intensively with in-home providers to improve her behavioral modification skills. One professional's strength was that she preferred flexibility in her work hours, which allowed her to be the expert 'on-call' for crisis or respite. Laura's 12 year-old aunt's strengths included enjoying outdoor activities, so she was built into the plan as a "professional playmate" for Laura. Finally, Laura's strengths included an affinity for drawing and coloring, which was built into her IEP at school, and a desire to learn karate, which was identified as an informal support in which the family could participate.

Another method of reinforcing a strengths-based approach in the team was the completion of a "normalization exercise" during the initial team training. Team members were presented with nine life domains (e.g., family, living situation, social/recreational) and asked to independently write down a number of important "norms" within each domain that were pertinent to Laura and her family. For example, "it is normal for kids. . . .to have someone to talk to, to have sleepovers, to have some privacy"; and "it is normal for parents. . . .to have lives of their own, to be able to work if they want to, to be safe," etc. This exercise was completed before the team defined the family's goals and needs, so that needs were identified that would enable the achievement of norms rather than merely address deficiencies.

Element 5: Culturally competent. For Cathy and her family, providers and team members, there were two primary levels of cultural awareness. Perhaps foremost, Cathy's need to maintain control of her own family's situation (something she referred to as 'driving her own bus') was identified as essential, despite her need for help. Previous providers had been reluctant to give Cathy control over planning and delivery of services, which was viewed as disempowering and detrimental to her ability to care for her children and grandchildren. Thus, providers and team members supported her desire to be at the center of the planning and coordination process, and to keep the children at home. A second cultural issue pertinent to the family was that Cathy was Caucasian, while her daughters and granddaughters were of both Caucasian and African-American descent. Providers and team members were diligent to schedule team meetings that would enable Laura's uncles -- who were African-American -- to attend, and to support "action opportunities" that involved these uncles and other African-American team members.

Element 6: Flexible funding. For Cathy and her family, a key to the achievement of a milieu of services and supports that were individualized and family-centered was the flexible funding mechanism employed by the interagency wraparound project. The project succeeded in 'blending' funds from the local mental health and social services agencies, augmented the pool with grant money, and sought reimbursement wherever possible. With this pool, the project was able to 'front' money to the team and family to buy whatever was necessary, including security deposits, automobile repairs, and $397 per month for a "relative placement" -- aid to Cathy beyond her public assistance allotment.2 Project staff dealt with the issues of reimbursement and unbundling of service and support funds at an administrative level.

Element 7: Balance of formal and informal supports. In order to achieve the overarching goal of "To keep Laura home and provide for safety," a number of needs and "action opportunities" were identified. The team decided that a number of these needs required formal services; however, each service was tied to a sub-goal of the overarching goal of keeping Laura at home safely. Formal services included family therapy (to work on how family interactions affected Cathy's caregiving and Laura's behavioral functioning); psychiatric services (to manage Laura's medication); "sexual assault services" (individual therapy for Laura which Cathy was allowed to observe in order to better understand Laura's sexual acting out behaviors), and an in-home worker (to aid Cathy and model behavior management). Wherever possible, however, family needs were met through informal supports. Some of these informal supports required

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2 Even with such an array of expenses, within two months, total costs for the family fell below the $4000 monthly expense that would have been required for a therapeutic foster care placement.

reimbursement, such as respite care (provided by a skilled and trusted neighbor) or karate lessons, while others did not, such as involvement of church members to support Cathy and to help her feel connected to her new neighborhood. Another mechanism employed by the project that encouraged use of informal supports was a rule that at least 50% of all team members be non-professionals.

Element 8: Unconditional commitment. The interagency wraparound project that served Cathy and her family had no exit or termination criteria; the project was committed to serving families until the family voiced that they no longer needed the intensive interagency services. This commitment was extremely important to Cathy and her family, who had previous experiences with providers who had discontinued services before the family was ready for such termination. The care manager's ability to obtain funds for the array of formal and informal supports also contributed to the sense of unconditional commitment. Finally, the team's collaborative creation of a 24-hour crisis plan in the initial team meetings that included responsibilities for both professionals and non-professionals reinforced a sense of unconditional commitment to the family. At the time of press, Cathy's family had been served via the interagency project for approximately one and one-half years. The significant improvement in Lisa's behavior and the family's functioning (and the concomitant reduction in overall service expenses) was viewed by the project as evidence of a successful intervention, but not as evidence of the need for termination of services.

Element 9: Collaboration. At the system level, collaboration between the local mental health and social services agencies enabled the project's flexible and blended funding scheme to be realized. The project's arrangement with FFCMH as a training facilitator and resource developer also was essential for the successful intervention scheme for Laura and her family. FFCMH designed the training protocol in which the family's team participated, and FFCMH advocates remained a primary point of contact with Cathy because of her trust in them. At the family level, as described above, team meetings were convened that included all service providers and informal supports as needed, while the care manager arranged for the reimbursement of funds expended.

Element 10: Outcomes determined and measured. For Laura's family, outcomes were set at macro- and micro-levels. One macro-level goal (move to a bigger house) was achieved rather readily, while the other (keep Laura home and provide for safety) required consistent revisiting, with outcomes for smaller intermediate goals set and measured. For example, Cathy and the team identified bedtime as a stressful and difficult time of day for Laura and the family, because of Laura's fears of going to sleep. As a result, the in-home interventionist created a behavior plan specific to bedtime that was monitored as a method of assessing progress, and that were also part of a behavioral reward system. Outcomes also were set around other activities and intermediary goals (e.g., success in tutoring over the summer, creation of a successful crisis plan). When outcomes were not being achieved, the team took that opportunity to re-assess the plan that was in place.

The project also maintained an overarching evaluation plan that informed the family's own assessment of outcomes. The project hired family members to independently assess the teams' successes through interviews. Interviews included an assessment across six service and family categories at baseline and at periodic follow-up points, evaluating, for example, the family's level of community supports, and the level of normalization of the child's educational and social domains. Such information was translated into easily interpretable pictographs for each family. For Laura's family, results revealed dramatic improvement in child behavior and parental empowerment over the first six months. However, the assessment also revealed that, despite the large number of informal resources, Cathy and Laura still had a need for more community supports -- Cathy in the form of neighborhood friends and contacts, and Laura in the form of playmates and friends at school.

APPENDIX C

Report of Joint Baltimore City/Montgomery County Child Work Group

Prepared for
The Department of Health and Mental Hygiene Medicaid and Mental Hygiene Administrations
under the auspices of
The Real Choices System Change Grant

Executive Summary

Submitted July 31, 2003

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INTRODUCTION

Children and adolescents with serious emotional disabilities ("SED") are in crisis. The service system is uncoordinated, expensive and often ineffective. Many children experience inappropriate institutional settings, custody relinquishment followed by foster care, or juvenile justice detention followed by pending placement. Children recycle from residential treatment centers to the community and back again. Statewide data indicates that for FY'02, 945 or 32% of the top 3,000 high cost users were under the age of 18. Average cost for residential treatment centers for this group was $75,256 for the year. To break this cycle and find a creative solution, a group comprised of representatives from Baltimore City, Montgomery County, the State Department of Health and Mental Hygiene, family members and some children's advocates convened in December 2002. The group is proposing a system of care for SED youth that provides services for each child's needs in the most effective and efficient modality, through the implementation of a Wraparound Case Rate Model in Baltimore City and Montgomery County.

VISION

The vision of the group is to develop a family- driven, community- based, inter-agency cooperative model that will be phased in over time and that will eventually be state-wide and systemic. The model must retain its locally driven character and each plan of care must be tailored to a particular child and family's individual needs. There must be a commitment to establishing a strong provider network which is oriented towards the system of care values and includes the involvement of families as equal partners at every level of decision making. The new system will bring a radical change for many providers. However, with flexibility and support, providers will be able to reformulate their organizations and staff to bring their strengths to new services. Once developed, implemented, monitored and evaluated, this new system can serve as a concrete model for providing treatment and services to children before they become high-end youth. In this way, the system operates not only as needed intervention, reducing the need for residential treatment, but also as prevention to further involvement in child-serving agencies.

OVERVIEW AND PLAN

Initially, a Wraparound Case Rate Model will be implemented in two jurisdictions: Montgomery County and Baltimore City. Individualized, flexible and effective services that are strengths based and family driven in accordance with the statement of values and principles described below are the foundation of the model. The case rate will be managed by care coordination units in conjunction with child/family teams and used to provide a broad array of formal and informal supports. The focus of the model will be on natural supports within the community and will reflect the culture of that community. There will be a commitment to the reduction of beds in the residential treatment facilities. The Mental Hygiene Administration's Administrative Service Organization (ASO) will offer eligible families the choice of enrollment in this project as an alternative to RTC placement. The first phase of the model will enroll up to 300 children. As success is achieved, the model will be expanded in subsequent phases and in other jurisdictions.

BACKGROUND

In 1999, Baltimore Mental Health Systems (BMHS)and the Family League of Baltimore City (FLBC), the local management board for Baltimore City, convened a group of state and local representatives to begin exploring the development of a partial capitation pilot for the City. This work commenced in response to the identified need for a program to better serve children and adolescents with serious emotional disabilities. In 2002, Montgomery County, having also identified this need, joined Baltimore and a broader group of partners to develop a proposal. A precursor of this planning was a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant, "The East Baltimore Mental Health Partnership" awarded to the Mental Hygiene Administration.

In Baltimore City, the FLBC has been providing wraparound services to a population of SED youth being returned from out-of-state residential treatment center placements since 1991. Called the Return/Diversion Program, this project has reduced the population of youth out-of-state from approximately 150 to below 25 and has served over 400 youth. Most youth have been maintained in community-based settings, including group homes, foster homes and natural families. The project has diverted millions of dollars from out-of- state expenditures back into community services for high risk youth. In addition, the FLBC has operated the Wraparound Baltimore Project for the past year. This project, modeled on the Wraparound Milwaukee program, serves 25 youth using grant funds from the sub-cabinet agency, the Office of Children, Youth and Families (OCYF). FLBC partnered in this project with the Department of Juvenile Services (DJS) to serve youth under DJS jurisdiction in the community rather than at RTCs or DJS detention facilities.

"Community Kids," an initiative of the Montgomery County's Health and Human Services Department and the Montgomery County Collaboration Council for Children, Youth and Families, has been developing wraparound services, interagency collaboration and family partnerships for SED children and their families. Community Kids is in the fourth year of a six year grant cycle. Over 200 SED youth and their families have been served using trained wraparound care coordination staff. Care coordinators have built child and family teams using natural supports, fee-for-service Medicaid services or limited private insurance services. The grant project has hired families of SED youth as staff to provide family-to-family support. The system of care project has worked to develop interagency partnerships, trainings, evaluation, and a functional data system.

Despite the accomplishments to date of these pilot projects, without a case rate model the grant's efforts will not be sustainable and families will not be able to receive the individualized services needed to keep children in the community with effective outcomes and overall cost savings. The model described herein will further the ongoing efforts in both localities.

SYSTEM VALUES

- Families as equal partners, at every level of decision making.
- The creation of flexible, creative, individualized services.
- Flexible and blended funding and financing to accomplish the values and outcomes.
- A system design that is sustainable over time.
- Quality services that can be monitored and measured through functional outcomes.
- A commitment to serving children and youth with high end needs.
- Effective and efficient service delivery.
- Family-driven, community- based, strengths-based and culturally competent.
- Value driven outcomes, structure and financing.
- A broad array of conventional and natural supports.
- Choice by and for children and families.
- A balance between fidelity for values and outcomes and flexibility to local and individual circumstances.

TARGET POPULATION

The goal is to first serve the highest end children, i.e., those with the greatest needs or who have been least well-served by the current service system, and who have the best chance for success with the wraparound approach. Children and adolescents must be under the age of 21, have a primary mental health diagnosis, may have underlying dual diagnoses, and must meet one of the following criteria:

- A child in an in-state RTC including both public (RICA) and private RTC beds.
- A child in an out-of-state RTC.
- A child receiving services through the FLBC Return/Diversion Program.
- A child receiving services funded by BMHS's inpatient diversion funds.
- A child who has had at least three psychiatric hospitalizations in one year or five in a two year period or has been in a psychiatric inpatient facility for more than 30 consecutive days or is classified as a "stuck kid."
- A child awaiting, recommended, referred or approved for RTC placement.
- A child committed or on probation to DJS, pending placement in a RTC.
- A child in the custody of DJS or DHR who has been diagnosed with a primary mental health diagnosis and also has a diagnosis of mental retardation with an IQ of at least 60 or a diagnosis of substance abuse.

In Phase I, which will be the initial year or two of implementation, it is recommended that between the two jurisdictions, there will be approximately 300 children enrolled and that within this group there will be at least10 youth from the DJS pending- placement category.

GOVERNANCE

The term "governance" for purposes of this Report refers both to oversight and policy setting and to systems management. Specific functions will include sustaining vision and values, developing outcomes, negotiating contracts, negotiating with the State to set rates, data system development and management, sustaining family support organizations, maintaining flow of the system, managing central accounts and training.

For the managing entity the choice is between a county-run system or one managed by a non-profit entity linked to government. The non-profit could be either a new or established corporation. Pros and cons of each approach were analyzed, and the details of this analysis are contained in the full Report. Baltimore City and Montgomery County will be using different approaches based upon differences in local structure and circumstances. Baltimore City will be managed through a non-profit corporation and Montgomery County will use a distinct, newly created Case Rate Unit within the county Core Service Agency.

FINANCING

Funding Plan

The Model anticipates using a single blended rate derived by blending existing funding streams. No new money will be required to serve the same size population. Instead, existing funds will be reorganized into a case rate so that these funds can be used most efficiently and effectively to provide appropriate services for this distinct high needs population. Savings from the reduction of individual RTC beds and the overall decreased use of high cost placements will be re-directed into the community.

This Model will use a case rate model. This case rate will pay for administration, family organizations, family support and all covered services. The case rate is a per person fixed payment for a specified period of time to cover services for an ***enrolled*** population. The actual amount of the case rate can be ascertained based on existing costs for this high-end population. There will be funds taken off the top to use for incentives related to scores on outcomes, training, risk and administration. Savings will be redeployed to create new services, including family-to-family supports, and to improve existing services for this high-end target population.

By blending as many of the different sources of funds as possible to develop a single-stream case rate to pay for all services will eliminate artificial service barriers, and unplanned, unproductive incentives.

Potential funds include Medicaid and non-Medicaid funds from the Public Mental Health System (PMHS), OCYF, DJS, Department of Human Resources (DHR) and the Maryland State Department of Education (MSDE). These funds can also serve as state match funds to leverage federal dollars. The first task will be to identify all potential pools of money and the likelihood of accessing these funds.

There is a clear need, in the current fiscal environment to have broad representation among participating State agencies. This is especially important for "state-only" funding streams which currently serve youth not matched by federal financial participation. There must also be a case rate that can support a broad range of flexible supports and services. Finally, the funding structure must ensure that the emphasis is on creative, strengths-based, family-driven and individualized services rather than on traditional, more restrictive services.

Medicaid dollars must be fully maximized. In Montgomery County, the first group of children to be enrolled will be Medicaid eligible. However, many children in need are not Medicaid eligible. Thus, there will be a concurrent effort to work with the major private insurers to develop a proposal that integrates the public and private systems for children in need. In Baltimore City, about 90% of the children in the target population are Medicaid eligible.

Funding Flow

As authority for the case rate is moved down, so is control and risk. The goal of a case rate which incorporates risk is to increase flexibility, integrate funding with clinical decision-making and allow for expanded, individualized and family-driven services, as well as decreasing reliance on expensive and restrictive services. There is a need to balance the locus of control and risk with the values of the wraparound approach. It is also important to find the best way within the local context to achieve maximum effectiveness. In both Montgomery County and Baltimore City, the case rate will be placed within the authority of the care coordination unit. The goal will be to include as many services as possible within the case rate. This issue may be re-visited in the pre-implementation phase as the rate is developed.

Rates

To recommend a rate-setting approach, the planning committee will analyze setting the rate based upon historical use data, a model service package, and other wraparound projects adjusted for local conditions. Setting the rate requires determining:

- the need for and payment mechanism for start-up costs;
- an effective rate that provides the most appropriate and efficient services;
- how that rate will be allocated between the relevant agencies over time;
- what percentage of the rate may be set aside for administrative costs, risk pools, incentive funds, and structured family support;
- how savings will be re-directed; and,
- how to negotiate the rate with all relevant agencies and parties.

The University of Maryland Baltimore County, through a DHMH contract, will provide technical assistance. State and Federal funding sources which currently pay for services for some of the target population will be assessed, and information gathered to analyze historical costs and in-cost allocation between agencies. A rate parameter will be specified so that negotiations with State agencies about their contributions can proceed.

STRUCTURE

Wraparound Model

Wraparound is a family-driven process, financed by a blended funding pool, which is focused on the individualized strengths and needs of the child, family and community. A plan of care is created that flexibly uses a combination of formal and informal culturally sensitive supports to achieve measurable outcomes based on an improved quality of life for each child. In practice, the clinical focus is on the child/family team that is facilitated by a care coordinator.

Referral

Referral means how a child is identified by the project. Once identified or referred, there will be assessment to assure that the individual meets the criteria and is eligible for enrollment. The referral process will be defined by whether there will be:

- a single referral point or multiple entry points;
- direct referrals from families and/ or a formal agency referral process;
- an opportunity for the family to enroll in this project as an alternative to the RTC prior to the certification by Maryland Health Partners (MHP) of an RTC placement, as well as how MHP and the courts might be involved.

The issue is to balance the need for an efficient and streamlined referral process so that the maximum number of eligible children is offered services while still ensuring that there is adequate access for families to the system.

In Baltimore, a plan was discussed to include a monthly meeting, hosted by the management corporation of a group comprised initially of representatives from the core agencies such as DJS, DHR/DSS, education, the courts, a family support organization and hospital representatives. Montgomery County is proposing to use a similar monthly interagency referral meeting except that families will also be able to directly refer to the management agency. There will be a comprehensive education process to clarify the eligibility criteria so that the families will have the tools to appropriately refer themselves. The family support organization will provide guidance and advice on implementation and provide oversight and guidance on the effectiveness of this aspect of the referral process.

Enrollment

After referral and certification of eligibility, the family will be given the choice of whether to enroll. Enrollment is voluntary. If the family decides to enroll, the formal enrollment will be to the management organization and then, following an initial assessment and review, the child/family will be assigned a care coordinator. Once enrolled, the case rate payment will be activated. There will be requirements that the child is seen within a reasonable time after enrollment and that there will be an initial individualized plan of care within one month.

Services

The model will provide for incentives to develop a broad provider network, combining both traditional and non-traditional formal services as well as informal and creative services.

Examples of traditional formal services:

- Case management
- In-home support
- Therapy/clinic and in-home
- Day treatment
- After school programs
- Respite
- Medication Services

Examples of non-traditional services and supports:

- Community camps
- Big Brother/Big Sister
- Art opportunities in the community such as music lessons
- Mentoring and tutoring in the community
- Family support activities and educational programs
- Family partners who assist enrolled families
- Recreation and participation in athletics and sports leagues
- Community conferencing and other dispute resolution mechanisms

Examples of informal services:

- Support in working as a volunteer
- Building natural neighborhood support groups
- Rites of passage programs

Graduation /Disenrollment

Voluntary disenrollment by the family must be carefully assessed. Monitoring mechanisms must ensure that care coordinators are providing high quality services, acting in good faith to "never give up," and taking all measures to solve problems. Involuntary or compulsory disenrollments will be specifically defined in the contract when it is impossible or inappropriate to continue to serve the child/family in this milieu.

In determining what constitutes successful "graduation," there should not be an arbitrary deadline for termination of services but neither should there be an expectation that the services are infinite. This is an individualized and flexible approach. Formal support for a longer period may be needed, especially for youth who may have a serious and persistent mental illness as they grow into adulthood. In other wraparound models nationally, families are typically enrolled for an average of 15 to 18 months.

Principles to guide decisions on length of stay for the model.

- Length of stay is stated as an average: there will be individuals with longer stays.
- Disenrollment/graduation will be decided on an individual basis determined by meeting certain criteria; not by a length of stay limitation.
- There will be phases of support: intensive, phased-down, aftercare.
- There will be a mechanism for support after the intensive phase so that a child does not seriously deteriorate before additional support is provided.
- The average length of stay will average 15-18 months.

Quality Management

Quality will be managed by a combination of training, ongoing management and evaluation of outcomes.

- intensive training in the system of care, wraparound values, and methods for implementing family-professional partnerships;
- standards of care or thresholds relating to the timeframes for the meeting of child/family teams, development and review of plans of care;
- individual benchmarks for each child to be measured periodically for aggregated profiles for review by family members, lawmakers, advocates, family and community organizations and the public;
- a series of outcomes that will be evaluated on an annual basis and the scores on these outcomes will be directly related to incentive funds and retention of any savings; and
- the involvement of family members, as well as family and community organizations will be critical in creating a feedback mechanism focusing on ensuring quality, and in linking data to social marketing strategies (e.g., testifying before legislative bodies, media advocacy, development of newsletters and websites).

Outcome domains will include increased:

- civic participation and community involvement
- family access to community care for target population
- child functioning
- emotional/behavioral functioning (including decreased detention, substance use etc.)
- social/peer relationships
- satisfaction of other agencies/providers
- cost effectiveness
- availability and use of culturally and linguistically appropriate resources
- family empowerment
- family satisfaction
- use of alternative and mainstream community resources
- family functioning
- success in school
- physical health
- financial stability for families
- child satisfaction/happiness
- safety for kids

Data Requirements Analysis

A workgroup representing Core Service Agencies, the Mental Hygiene Administration, the Montgomery County School System, Montgomery Community Kids, and the Local Management Boards from Baltimore City and Montgomery County was appointed to begin the process of identifying the functional requirements for a management information system (MIS) for the wraparound project. Two meetings of the MIS Workgroup were held in early May 2003. In addition, discussions were held with the Office of Children, Youth and Families.

The MIS should be Web-based to provide for a range of age groups and facilitate the transition of youth, adults and families, have secure contemporary encryption, comply with all HIPAA regulations, be consent driven by the families and individuals being served, and reflect the project values throughout the system.

LOCAL MODEL: MONTGOMERY COUNTY

Montgomery County is planning to use a county unit established and specifically targeted to managing the case rate project. The care coordinators will be housed in this county unit and the case rate will remain at that level within their authority.

Features

- Discrete county unit with central functions as described below.
- Case rate integrated with clinical decision-making.
- a child care coordination unit within the county unit.
- The case rate will be collected from the state at the county level.
- Funds will be deducted for incentive, administrative, training and risk pools.
- Care coordination teams with care coordinators and a supervisor.
- Risk and incentives held by the care coordination unit at the county government level but there might be variations as the project evolves, i.e., contract incentives (bonuses) to providers of aggregate services who achieve specific outcomes.
- Children's care coordination unit will be authorized to purchase services.
- Care coordination unit will be measured by outcomes, and county will retain savings.
- Family support organization at county level

County Unit Functions

- Develop vision, inculcate and continually instill values.
- Training for all case rate staff, families/consumers, agencies and provider community.
- MIS/Data.
- Contract with and accountability to State agencies.
- Ongoing quality assurance and outcomes evaluation.
- Management of system (e.g., meeting with agencies and staff, training, site visits)
- Monitor enrollment and approve disenrollment.
- Interface with other county units, e.g. clinical director, ACCESS team, data, finance.
- Negotiate rates.
- Set fee-for-service rates.
- Youth and family consumer grievance.
- Facilitate inter-agency advisory.
- Bill/cost reporting other agencies.
- Facilitate inter-agency referrals.
- Determine location and functions of family support organizations.

Care Coordination Unit

- Facilitating and developing child/family teams.
- Determining services along with families.
- Administering the case rate, which pays for all utilization management decisions including inpatient needs.
- Continually work with other providers.

LOCAL MODEL: BALTIMORE CITY

Baltimore City plan is to have a two-level structure. BMHS/FLBC will have the overall governance authority for the project and will have a Project Director. The central accounts will be held at this level and this agency will contract, using a case rate, with the Care Management Agency (CMA). The contract will include outcomes, values, and threshold requirements. The CMA will either be an existing provider entity or a new non-profit organization established as an affiliate of BMHS. If a new agency is created, the Board of Directors of the new agency will be comprised of representatives from the other child care agencies (DJJ, DSS and Baltimore City Public Schools) and family members. If an existing entity is used, it will create an advisory board for this project comprised of the same representatives described above. The teams will be expected to purchase the discrete services authorized by the child/family teams. The family support organization will assign staff to each child/family team.

Features:

- Governing agency sets policy, values, organizes training, builds provider network, and serves as arbiter and overall manager.
- CMA holds case rate, manages care, monitoring, evaluation and oversight.
- Case rate and care coordination are united.
- The care coordinators will have discretion to buy or provide service, but outcomes will include focus on purchasing and using natural supports and informal services.
- Shared risk since CMA pays for all services out of the rate, but there will be a stop loss/disenrollment contract provision, and BMHS/FLB will have use of the risk pool.
- Families involved at every level; family support organization working with care coordinators.

BMHS/FLB Functions

- Contract with CMA; collect and pay case rate, deducting off the top funds for an incentive account, risk pool, training account and administration.
- Through these central accounts develop and guide behavior towards values, goals and outcomes; provide overall quality management.
- Negotiate with state agencies.
- Conduct or contract for yearly evaluation.
- Administer central accounts.
- Grievances.
- Provide systems training, and manage data/MIS.
- Develop broad provider network, set policy for network, certify providers.
- Re-invest savings in new services and training.

CMA Functions

- House care coordinators and child/family teams.
- Manage case rate and services; achieve outcomes.
- Inter-agency board including family members, meet monthly and provide oversight.
- Bill/pay providers of purchased services.

NEXT STEPS and TIMETABLE

As the next steps proceed in the development of the model, there will be ample opportunity to address on going considerations and emerging issues, e.g., start-up costs and how will those costs be financed; whether there will there be financial support if a youth "graduates" from the intensive wraparound model but is supported in an aftercare phase.

1**.** BMHS will send the Report to DHMH which will then disseminate it to other State Agencies through departmental channels, and will include related recommendations to the Governor being developed by the Council on Custody Relinquishment.

2. MHA and Medicaid Administration, through the resources of the Real Choices grant project will make available additional consultation funds for both Montgomery County and Baltimore City.

3. The planning committee will continue to meet and will work with a team convened by DHMH to work with UMBC consultants in collecting interagency cost data from selected agency sources and commence working toward developing a blended rate in order to maximize federal funding. The rate will be negotiated by and between all parties.

4. Local jurisdictions will disseminate and review the Report to determine details related to local models.

5. Local implementation strategies, including marketing, public education and training, will be developed.

6. Ongoing discussions and negotiations will occur between state agencies. The negotiations will use the data from UMBC and the rate group to support committing funds to the project.

7. Contract negotiations between DHMH and local jurisdictions will begin. These negotiations presuppose a fully described model and a framework for addressing issues of roles, responsibility and accountability.

8. A second report will be completed by January, 2004 describing the complete models with implementation dates to include a goal of developing a Request for Proposals by February, 2004, and the enrollment of the first consumers by late April/early May 2004.

GLOSSARY of TERMS and ACRONYMS

BMHS	- Baltimore Mental Health Systems
CMA	- Care Management Agency
DHMH	- State Department of Health and Mental Hygiene
DHR	- Department of Human Resources
DJS	- Department of Juvenile Services
FLBC	- Family League of Baltimore City
JJ FAIR	- Juvenile Justice Family Advocacy Initiative & Resources
MARFY	- Maryland Association of Residential Facilities for Youth
MC CCC	- Montgomery County Collaboration Council for Children
MC HHS	- Montgomery County's Health and Human Services Department
MHA	- Mental Hygiene Administration
MHP	- Maryland Health Partners
MIS	- management information system
MSDE	- Maryland State Department of Education
OCYF	- Office of Children, Family and Youth
PMHS	- public mental health systems
RTC	- residential treatment centers
SAMHSA	- Substance Abuse and Mental Health Services Administration
SED	- serious emotional disabilities